Nestor Primecare Services Limited

Allied Healthcare Kettering

Inspection report

Unit 2 Kings Court
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15 July 2016
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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 15, 20 July and 3, 5, 10, 12 and 15 August 2016 and was announced. Allied Healthcare – Kettering is a large Domiciliary Care Service, which provides personal care for people in their own homes. The inspection was undertaken by one inspector.

The service did not have a registered manager in post. The previous registered manager had left the service in February 2016. A new manager had been appointed and they had applied to be considered for registration with the Care Quality Commission (CQC). At the time of the inspection their application was in progress. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were not always informed about staff changes and of which staff may be visiting them. Having unfamiliar staff regularly attended their care, caused some people unnecessary anxiety and frustration.
The scheduling of work did not always allow staff sufficient time to travel from one visit to the next.
Contingency plans were not always effective to allow for the service to provide cover for short notice staff absences, which sometimes left staff compelled to work when they were unwell.
Robust staff recruitment processes ensured that staff employed to work at the service had the right mix of skills, knowledge and experience and were suitable to work with people using the service.

Staff knew how to recognise signs of abuse and of what they needed to do to protect people from abuse. Risks to individuals and their home environment were identified and managed. Risk assessments were centred on the needs of the individual, to enable people to live at home safely and independently within their capabilities.

Where the service was responsible appropriate systems were in place to manage medicines. Staff supported people to take their medicines safely.

Staff received appropriate training to equip them with the knowledge and skills to meet the range of needs of people using the service. A staff mentoring scheme ensured that staff were fully supported through their induction and probationary period. Regular supervision and annual appraisal meetings provided continual staff support systems.

The principles of the Mental Capacity Act (MCA) 2005 were followed when assessing people's capacity. The staff were knowledgeable of the requirements of the MCA legislation and ensured that consent was obtained before providing people with their care.

Where the service was responsible, people were supported to have a balanced diet that promoted healthy eating. Staff met people's day to day health and welfare needs and took appropriate action in response to

changing health conditions requiring medical intervention.

People's needs were assessed and their care plans had sufficient detail to reflect how they wanted to receive their care and support to be provided. People using the service and/or their relatives were involved in the care reviews.

People were treated with kindness and compassion and their privacy was respected. The staff understood and promoted the principles of person centred care.

Complaints were responded to appropriately and used as an opportunity for learning and improvement. The manager understood their responsibilities and they were knowledgeable of the needs of all people using the service. Staff aimed to deliver a quality service and staff at all levels understood and promoted the ethos and vision of the service.

Management systems were in place to measure and review the quality of the service people received and drive continuous improvement.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Frequent staff changes and unfamiliar staff regularly attending to people's care caused some people unnecessary anxiety and frustration..

The scheduling of work did not always allow sufficient time for staff to travel from one visit to the next.

Contingency plans were not always in place to allow the service to provide for short notice staff absence cover.

Staff knew how to recognise signs of abuse and what to do to protect people from abuse.

Risks to individuals and their home environment were identified and managed.

The recruitment systems ensured that only staff that were suitable worked at the service.

Where the service was responsible, people's medicines were managed appropriately.

Is the service effective?

Good

The service was effective.

Staff received appropriate training to provide them with the knowledge and skills to meet the range of people's needs.

Staff received support through regular supervision and appraisal systems.

The requirements of the Mental Capacity Act (MCA) 2005 were met and people's consent was sought before staff provided their care.

Where the service was responsible, people were supported to have a balanced diet that promoted healthy eating.

People's changing health conditions were closely monitored and staff worked with other healthcare professionals in response to meeting the changing needs.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and compassion.

Staff ensured people's privacy and dignity was respected.

Staff understood and promoted the principles of promoting independence and person centred care.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and the care plans had sufficient detail to reflect how people wanted their care to be provided.

People using the service and/or their representatives were involved in care reviews.

Complaints were responded to appropriately and were used as an opportunity for learning and service improvement.

Is the service well-led?

Good

The service was well led.

A manager had been appointed and had applied to register with the Care Quality Commission (CQC). Their application was in progress.

Staff at all levels understood the vision and values of the service.

Quality assurance systems were used to measure and review the delivery of care and drive continuous improvement.

Allied Healthcare Kettering

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 15, 20 July and 3, 5, 10, 12 and 15 August 2016 and it was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service to people living in the community, and we needed to be sure that someone would be available in the office. The inspection was carried out by one inspector.

The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We received the completed document prior to our visit and reviewed the content to help focus our planning and determine what areas we needed to look at during our inspection.

We reviewed other information we held about the service including statutory notifications that had been submitted to the Care Quality Commission (CQC). Statutory notifications include information about important events which the provider is required to send us by law. We also received feedback from commissioners involved in the care of people using the service.

We spoke with five people using the service and the relatives of three people using the service. We spoke with the acting manager, the care delivery manager, the area operations manager, the Regional Hub Manager and nine care staff.

We reviewed the care records belonging to ten people using the service to check that they were reflective of people's current needs. We reviewed four staff files that contained information about their recruitment, training and support. We also looked at other records relating to the quality assurance and management of the service.

Requires Improvement

Is the service safe?

Our findings

Feedback received from people using the service, relatives and staff indicated that staffing arrangements were not always sufficiently robust, to enable consistency of staff for people using the service. One person said, "I usually have the same member of staff, they know me very well, but things have been up in the air more recently, I have been having different staff coming to provide my care, I think it may be due to the school holidays, I'm hoping it will only be temporary". One relative said, "We used to always have the same carers, we had a really good relationship with them but now we never know who is going to turn up, it makes life very awkward, its pot luck who arrives at the door". They also said, "We used to get a staff rota each week, but we haven't had one for a while now". Another relative said, "Recently the staff that have been coming here, ask me what they need to do instead of looking at [Name of person's] care plan, I don't know what they would do if I wasn't around".

The staff told us they thought there was sufficient staff available to meet people's needs. They spoke of working with other members of staff where a 'double up' call was required to care for people with higher physical dependencies, needing two staff to operate moving and handling equipment safely. One member of staff said, "We work well as a team, we try to cover for each other whenever one of us are away on holiday or off sick". Another member of staff said, "Once I had a really bad chest infection and felt very ill. I phoned the office to call in sick, but I was told there was no one else to cover for me, I felt guilty and went into work, I know I shouldn't have really". Another member of staff said, "If you fall ill suddenly, you feel compelled to still go out and do the visits, it is difficult for the staff in the office to cover your shift at short notice".

The service sometimes expected staff to provide care within a timescale that had a potential to make people feel rushed and leave little flexibility for staff to respond appropriately to people's changing needs. People told us the staff providing their care usually arrived on time, but some people expressed concerns about staff not being allocated sufficient travel time between calls. One person said, "Whenever the staff are running late, they always try to call me to let me know what's happening". A relative said, "We know that the staff are up against the clock to get to the next person. If they have finished everything here, we tell them its okay to leave a bit earlier. We understand the pressure they must be up against". A member of staff said, "When we have no travel time allocated, how are we supposed to get from one end of town to the other in 0.0 seconds?, we have been told that travel time is going to be put in, but it hasn't happened yet". Another member of staff said, "I once called for an ambulance for a person who I found had, had a mini stroke. I called their son who arrived as soon as he could. I felt really guilty that I had to leave; I felt I should have stayed with them for a little while, just to help out and give some reassurance. But I was told I had to leave go to my next call, as there was no one else available to cover it". We saw on the staff rotas that some visits were scheduled back to back, whilst some did have time allocated for travel between the visits.

People using the service and their relatives told us they thought the service ensured their safety and welfare. One person said, "I had a bad fall and broke my leg, I ended up in hospital, I am now totally dependent on using a zimmer frame (walking aid). The staff are good at helping me move about with it safely, they always make sure I have it right beside me before they leave".

The staff we spoke with confirmed they had received training on safeguarding people from abuse and on the safeguarding reporting procedures. One member of staff said, "If I found any of the people I visit were at risk of abuse I would report it to the office immediately". Another member of staff said, "We are informed in the training how to report abuse, if I suspected or saw any abuse I would know exactly what to do about it". We saw records held within the staff files that itemised that safeguarding as one of the mandatory elements for all staff to complete during their induction training. We also saw that refresher safeguarding training was provided for all staff annually. The provider's safeguarding policy gave the contact details for the local authority safeguarding team and also the contact details for the Care Quality Commission (CQC) for staff to use when reporting any concerns of abuse.

Suitable systems were in place for staff to record accidents and incidents. The manager of the service was aware of their responsibility to notify the Care Quality Commission (CQC) of all incidents of abuse and other incidents that resulted in serious injury to the person.

Risk assessments identified specific risks presented to people using the service and staff within the home environment. They outlined the key areas of risk, such as falls, medication, equipment and manual handling needs and any concerns as to how pets responded to staff entering the home. They included information on the action staff needed to take to promote people's safety and minimise any potential risk of harm, whilst promoting people's autonomy and independence. We saw the risk assessments were reviewed regularly and updated as and when people's needs changed. We saw that emergency contact details were available within people's care records. Such as, the person's GP and other health and social care professionals involved in their care. Their next of kin, friends and neighbours' contact details.

The recruitment systems made sure that the right staff were recruited to keep people safe. The staff we spoke with confirmed that the provider had carried out appropriate checks on their eligibility and suitability to work at the service. We saw that the recruitment process ensured that applicants were suitable to be employed at the service. Written references were obtained from previous employers and where this was not pertinent personal character references had been obtained. The staff recruitment files contained documentation to verify the applicant's identity and their eligibility to work in the United Kingdom. We saw that enhanced Disclosure and Barring Service (DBS) checks had been carried out, which ensured that only people that were suitable to work with vulnerable groups, adults and children were employed to work at the service.

Where the service was responsible, the staff managed people's medicines appropriately. People using the service confirmed the staff signed the medicines administration records (MAR) documentation held within their homes on administering their medicines. One person said, "My medicines are kept in a dosset box, the staff get the tablets out for me and give them to me, they then sign the record sheet to show that I have taken them". A relative said, "When the staff call on [Name of person] they always check they have taken their tablets". The staff told us they completed medicine training that included the administration and recording of medicines. We saw records of this training being provided within their training records.

Staff said that they found the medicines training very informative and that it prepared them with the knowledge for administering people's medicines. We saw that the provider carried out medicines competency assessments on staff that included observing them administering people's medicines. They also carried out reviews of the MAR charts held within people's homes to ensure the staff were following the procedures of correctly administering and recording medicines. We looked at the MAR charts for some people for which the provider had taken on the responsibility for administering their medicines. We found they were completed and signed appropriately by the staff. One area brought to the attention of the provider at the time of the inspection was to ensure that staff record on the MAR charts when they have

applied prescribed creams for people using the service. The provider said they would address this area immediately.

Good

Is the service effective?

Our findings

The service made sure that the needs of people were met by staff who had the right competencies, knowledge, qualifications, skills, experience, attitudes and behaviours. One relative said, "We have only recently started using the agency, and all the staff that have so far attended [Name of person] calls, seem to know what they are doing". Another person said, "I feel the staff are properly trained, I have never had any concerns, I see that they have spot checks carried out to check they are doing things right". At the time of the inspection we met with six new staff that were undertaking the four day selection training course facilitated by the company trainer. One member of staff said, "I have experience of care work, but it is always good to update your knowledge". They all said they had been given homework to do, that they were enjoying the training and found it very informative. All staff were supplied with a learning and development portfolio that contained copies of the selection training presentation that covered the core skills of a care worker and distance learning workbooks. There was a dedicated training room with a range of moving and handling equipment available for staff to use when undertaking moving and handling practical training sessions.

Newly recruited staff did not work alone unsupervised until they and the provider were confident they were competent to do so. One member of staff said, "The training is excellent, it is very professional". The provider told us in their provider information return (PIR) that once staff had completed their core induction training they then went through a 12 week probationary period. During which coaching and shadowing took place that consisted of a 'pre start' meeting with a nominated care coach and shadowing shifts. Each new member of staffs first shift was follow up by a member of the branch team. An unannounced spot check was carried out within the first three weeks, and further reviews of their performance took place at intervals of four, eight and 12 weeks. We saw within the staff files that the procedures were followed in practice and recorded.

A programme of staff supervision and performance appraisal meetings was in place. The staff confirmed they met regularly for one to one supervision with their supervisors and that they had also attended group staff meetings with the provider. We saw that minutes were kept of the supervision and appraisal meetings within the staff files. We also saw that minutes of staff group meetings were available. This demonstrated that staff had opportunities to discuss their performance and learning objectives and any work related matters and receive communications from the provider. We also saw that the provider used social media to share information about the service and any benefits which were available. This ensured that staff had a range of information available to support them with their work.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack the mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for domiciliary care services is called the Court of Protection.

People using the service and relatives told us that staff always sought their consent and permission before they carried out any task or personal care. Staff told us they had received training on the MCA 2005 and there was evidence of this within the staff training records. We saw that people had MCA assessments carried out and where they had been assessed as lacking the capacity to make decisions 'best interest' decisions had been made on their behalf following the MCA 2005 legislation. For example, best interest's decisions had been made for people who lacked the capacity to safely manage their own medicines.

People said that the staff prepared and heated ready meals for them. One person said, "I am in a wheelchair and find it difficult to reach the work surfaces in the kitchen, the staff help me to prepare meals and to reheat ready meals in the microwave". The staff told us when they visited people's homes they ensured that people had food and drinks available to them. We saw that people's care records contained information about their dietary needs and preferences and the level of support needed to eat and drink sufficient amounts.

People were supported to access health services as required. The staff told us they had contacted relatives and the GP in response to changes in people's health conditions. One member of staff said "I arrived at [Name of person's] home and found they had taken seriously ill, I called an ambulance and contacted their relative, I stayed with them until they arrived". We saw within people's care files records of when staff had made contact with other healthcare professionals in response to the person's changing needs. For example, one person's mobility had greatly decreased and the support of an occupational therapist had been sought.

Good

Is the service caring?

Our findings

People received care and support from staff that knew and understood them and were aware of their preferences likes and dislikes. One person said, "I am very pleased with everything, the staff are very caring". Another person said, "The staff are very easy going and chatty, I like that it helps the day go by". One relative said, "We have good relationships with the staff, we know and trust them, they always treat [Name of person] with kindness and compassion". Another relative said, [Name of person] is not against male staff providing his care, but he does respond better to female staff, we generally have female staff attend to his care". One member of staff said, "I treat people like I would want to be treated, with respect. I always think, I may need to have someone look after me in the future, it gives you a feeling of what it's like to be on the receiving end".

People spoke of how the staff treated them with companionship. One person said, "The staff are very friendly I get on very well with them, we chat as they go along their duties". The provider told us in their provider information return (PIR) that privacy, dignity, respect, kindness, compassion were a constant theme within the core staff training. They said that the care coaching systems in place enabled staff mentors to demonstrate and guide staff in putting into practice the core principles, which were a key foundation in the way in which care was provided for people using the service. They also told us that when allocating staff they tried to match staff according to people's preferences, likes and dislikes to provide personalised care.

Arrangements were in place for people to plan their own care and their views were listened to and acted upon. People and relatives told us they were consulted and fully involved in planning their care. One relative said, "When we first started somebody came out to see us to discuss what sort of package of care we needed. The care plan has been tweaked here and there, we recently had a meeting and have asked for the morning call to be brought forward, I think they are seeing what can be done and am waiting to hear back from them".

People's independence was promoted so that people maintained their skills. One person said, "The staff are very good at gauging what I can do for myself and when they need to step in and help. While I am relatively fit I like to do as much for myself as possible, the staff help out when needed". We saw that people's care plans recorded the skills and abilities of people using the service.

Good

Is the service responsive?

Our findings

People using the service and their relatives told us they were involved in assessments of their care and their care plan reviews. One relative said "They did an assessment for [Name of person] when we first started using the service, they involved me as I am the main carer". Another relative confirmed their family member had regular care reviews they said, "Someone from the office comes out to see us to ask how things are going, sometimes they phone to ask how things are going".

People told us they generally received the care and support they needed and were given a choice about who provided their personal care. However some people said that more recently they been receiving staff into their homes that they had never met before. One relative said, "Everything is fine when we have or regular staff, things are not so smooth running when we don't, they ask me what they need to do instead of referring to the care plan". We saw that staff kept contemporaneous notes in the daily notes held within people's homes to record the care and support they had provided for people on each visit.

The care plans that we reviewed contained sufficient information about the needs of the person for staff to follow in meeting their health and welfare needs. They had been reviewed and updated as and when people's needs had changed. However one person told us that the needs of their family member had changed significantly over the past 12 months and the care plan held within their home had not been updated with information on the current situation. We brought the person's concerns directly to the attention of the provider who confirmed they had arranged for a meeting to take place to investigate the issues.

Complaints made to the service had been responded to and investigated appropriately following the provider's complaint procedure. One relative said. "I have complained to the office before, they listened to me and sorted things out very quickly. I'm not a big complainer but when I feel strongly enough about something I will say". Another relative said, "I have never had any concerns, so have never needed to make a complaint, if I ever did I feel the agency would take it very seriously". People confirmed they had the contact details and information on how to make a complaint within the documents held in their homes.

We saw that the provider used a computerised system to record complaints, incidents and accidents called CIAMS. We were told the system automatically notified the relevant people within the organisation to ensure that all the information could be responded to quickly and effectively. The provider also told us they used feedback received from customer satisfaction surveys, complaints and general telephone calls to the branch to ensure complaints were responded to appropriately and where any failings were identified lessons were learnt to continually improve the service.

Good

Is the service well-led?

Our findings

There was not a registered manager in post. The registered manager left the service in February 2016. A new manager had been appointed and they had submitted a registered manager application to the Care Quality Commission (CQC) that was in progress.

We received mix views on the quality of the service. But overall people using the service and their relatives generally satisfied with the care they received. Records were held within people's care files of them being asked about the quality of the care they received through face to face home visits and telephone surveys being carried out. People generally felt that the manager and staff listened to their feedback and suggestions and where possible they were always accommodated. The provider told us that the latest survey was currently in circulation and this was also confirmed by the people we spoke with. One person said, "I have just provided some feedback the main area they need to focus on is around staff continuity, so we don't have so many different faces coming and going all the time".

The provider had kept the Care Quality Commission (CQC) informed of events and incidents, as legally required under the registration regulations. Safeguarding procedures were in place and communicated with all staff to ensure they were all aware of their responsibility to protect all people using the service from the risks of abuse. Staff were aware of the whistleblowing procedures and their responsibility to report any abuse to the local safeguarding authority, if they believed the manager or provider did not take appropriate action to protect people from abuse.

Systems were in place to provide staff support and training. The staff we spoke with were positive about the management of the service; they said they received good training and support. One member of staff said, "It is a professional organisation the training and support is excellent". Regular one to one meetings took place to review staff performance and general staff meetings took place with the provider and staff to communicate information and updates to policies and procedures. The meetings were planned in advance and records were maintained of items discussed on the agendas.

We saw that suitable systems were in place to regularly audit the quality of the service. They included checks to people's care plans, risk assessments and medicines records. Areas identified for action were prioritised using a traffic light system (RAG rating) and actions plans put in place with set timeframes for completion.